February 16, 2010

Testimony of Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities before the Select Committee on Aging Public Hearing

Good morning Senator Prague, Representative Serra and to the members of the Select Committee on Aging. My name is Matthew Barrett and I am Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), our state's 110 member trade association of proprietary and nonprofit nursing homes. I am pleased to have this opportunity to testify on several bill's on today's public hearing agenda.

S. B. No. 103 (RAISED) AN ACT CONCERNING ACCESS TO OMPREHENSIVE FACTUAL INFORMATION REGARDING LONG-TERM CARE FACILITIES.

This legislation proposes three changes to the established patient's bill of rights found under subsection (b) of Section 19a-550 of the general statutes.

There is no objection to the first recommended change in subdivision (b)(2) as requiring information about staff-to-resident ratios is already required by federal law.

However, the proposed change to (b)(10) would create a vague standard in asserting that a nursing home utilizes the "most appropriate and best care practices." There is no agreement on what the "most appropriate and best care practices" are. So it is unfair and misleading to consumers and for a nursing home to say a home is using the "most appropriate and best" ones. As such, this would expose nursing homes to liability for not using a particular "care practice" even when, for example in wound care, there is considerable disagreement about best practices.

Moreover, to the extent that the federal Interpretive Guidelines (which accompany the federal regulations governing nursing homes operations) can be read as prescribing particular practices, then nursing homes are already required to follow these practices by federal law. It is illustrative that there are already over 400 separate resident care requirements (all of which have Interpretive Guidelines) that nursing homes must follow under federal law. It is instructive that the federal prescriptions do not mislead using the word "best."

For similar reasons, our association objects to the proposed change in subdivision (b)(16) requiring 5-Start reporting. The 5-Star system has been the subject of much dispute. Connecticut's Attorney General has joined other states' attorneys general in asking the federal government not to utilize this system until these issues can be resolved. Yet, this bill would require nursing homes to give this information out as if it were the definitive statement on quality. It is one measure and available for consumers and their families on the CMS web site.

S. B. No. 104 (RAISED) AN ACT ESTABLISHING A CAUSE OF ACTION FOR NURSING HOME FACILITIES AGAINST RECIPIENTS OF TRANSFERS OF ASSETS.

I am please to lend our associations support for this legislation and I thank the leadership for raising the bill for hearing today. Nursing homes are frequently required to give free care when there has been a transfer of assets, and this free care is not reimbursed as part of the facility's Medicaid rates. This legislation provides at least some opportunity for reimbursement to the home, and I urge passage in the committee.

For the committee's information, the transfer of asset Medicaid penalty period begins when the resident is "otherwise eligible" for Medicaid, i.e. has only $1600 in assets. The length of the penalty period is determined by DSS, by dividing the amount of money or value of the asset transferred by the average private pay cost of care in a nursing home. This is currently almost $10,000 per month, as determined by DSS. The transfer must have been made within five years of the filing of the Medicaid application. The penalty period begins as of the date the resident is below the Medicaid asset limit.

So if someone transferred a house worth $200,000 to a child and then within five years became eligible for, and applied for Medicaid, the resident would be ineligible for Medicaid for 20 months. The 20-month period would begin when the resident applied for Medicaid -- a point at which, by definition, the resident has no money. So the nursing home is left to care for the resident for free because the resident by definition has no money and Medicaid won't pay. The resident can't be discharged because (a) they can't go home and most often has no home to go to; and (b) no other nursing home will accept him/her under these circumstances. There is a very restrictive and limited hardship exception under which DSS will pay, but this applies to only a very small percentage of cases.

S. B. No. 105 (RAISED) AN ACT CONCERNING LIABILITY OF NURSING HOME OWNERS FOR NEGLECT AND ABUSE OF NURSING HOME RESIDENTS.

This legislation is unnecessary and demeaning to nursing homes. Abuse of the elderly anywhere is a crime and there is no reason to single out nursing homes from hospitals, residential care homes, assisted living or other settings where the elderly reside.